

The design of a national module on leadership and governance for family physicians

1. Introduction

This workshop was held at the Hotel Verde, Cape Town International Airport on 21-22 April 2015.



One objective of the project “Strengthening primary health care through primary care doctors and family physicians” is to build the capacity of family physicians to offer effective leadership and clinical governance to PHC facilities. The activity related to this is to develop a national training module on leadership and clinical governance for family physicians that is incorporated into all training programmes. This workshop was intended to explore the topic and reach a national consensus on the design of this module.

2. Attendance

The workshop brought together the partners in the project together with key stakeholders.

Abdul	Isaacs	University of Cape Town
Andrew	Ross	University of Kwazulu Natal
Bernard	Gaede	University of Kwazulu Natal
Bev	Schweitzer	University of Cape Town
Bob	Mash	Stellenbosch University

Busi	Cawe	Walter Sisulu University
Colette	Gunst	Cape Winelands District
Derek	Hellenberg	University of Cape Town
Gboyega	Ogunbanjo	Sefako Makgatho Health Sciences University
Gerhard	Botha	University of Pretoria
Hannes	Steinberg	University of the Free State
Indiran	Govender	Sefako Makgatho Health Sciences University
Julia	Blitz	Stellenbosch University
Kerrin Nicole	Begg	Stellenbosch University
Klaus	Von Pressentin	Stellenbosch University
Laura	Campbell	University of Kwazulu Natal
Laurel	Baldwin-Ragaven	Witwatersrand University
Linda	Muriethi	University of Cape Town
Lizette	Phillips	Cape Winelands District
Mohammed	Shoyeb	University of Limpopo
Nathaniel	Mofolo	University of the Free State
Richard	Cooke	Witwatersrand University
Selma	Smith	University of Pretoria
Shadrick	Mazaza	Oliver Tambo Fellowship Programme
Parimalaranie	Yogeswaran	Walter Sisulu University
Zandy	Rosochacki	Stellenbosch University
Zelra	Malan	Stellenbosch University

3. Presentations on leadership and governance

In the first session a number of presenters set the context for this discussion and shared key ideas and concepts. These presentations are briefly outlined here and are podcast at URL:

<http://fmhspod.sun.ac.za/Podcasts/FamilyMedicine.aspx?aid=2823>

PDF versions of the presentations are available from the following URL:

<http://www.sun.ac.za/english/faculty/healthsciences/Family%20Medicine%20and%20Primary%20Care/national-module-on-leadership-and-governance>

Dr Lizette Phillips: Clinical Governance Framework from the perspective of the Cape Winelands District.

Dr Phillips shared the Western Cape Department of Health's clinical governance framework and how the Cape Winelands District has implemented this framework. She talked about the central role of the family physician and the lessons learnt.

Clinical governance framework WCG:H 2010

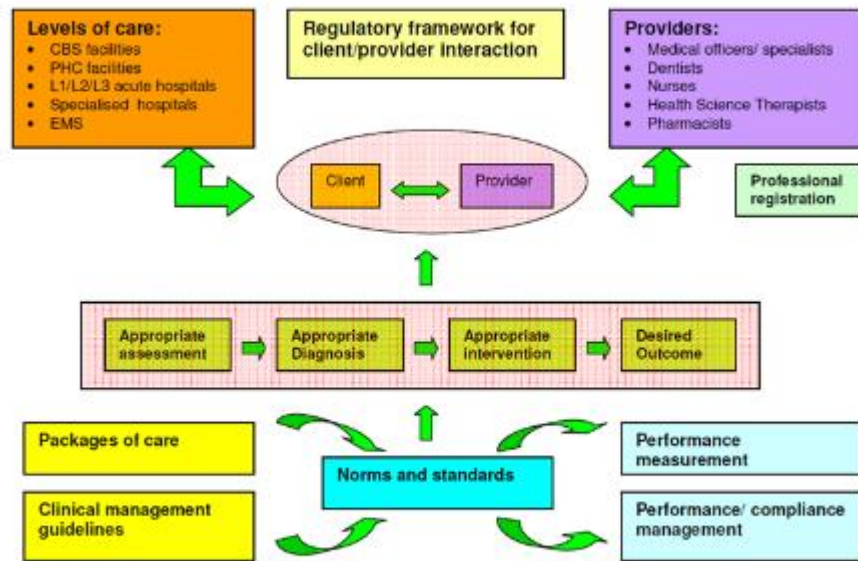


Figure 2: Clinical Governance Framework



Dr Linda Mureithi: Development of a Framework for DHS Management, Clinical & Support Staff and Standardised Job Profiles

Dr Mureithi outlined a project to nationally define the District Health Management Team (DHMT) and the job profiles. This project is being driven by Health Systems Trust for the National Department of Health. It is clear that the family physician is not seen as a full time manager or core member of the DHMT but provides leadership, clinical and corporate governance through various positions in the District. Family physicians may be placed in the District Clinical Specialist Team, within the district hospital services or primary care services.

Dr Laura Campbell: Strengthening training in medical leadership at the University of Kwazulu-Natal: a scoping review

Dr Campbell performed a focused literature review on the topic of medical leadership with regard to the training of family physicians. One useful model of medical leadership is shown below:



Source: Medical Leadership Competency Framework; NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges 2010

Essential knowledge with regard to leadership may be:

- Insight into one's own preferred leadership style and role
- Making sense of the environment within which you are a leader
- Some knowledge of leadership theories

Leadership is not a separate role, but an attribute of the family physician that should manifest in all of the six roles: care-provider, consultant, capacity-builder, supervisor, champion of clinical governance and COPC.

Teaching should focus on self-awareness, self-confidence, values and vision as a leader. Action learning and 360 degree multi source feedback may be particularly useful in the workplace, combined with virtual on-line leadership development programmes.

Dr Kerrin Begg: Overview of Post-graduate Diploma in Healthcare Management

Dr Begg presented the new Diploma in Healthcare Management that is offered at the Division of Community Health, Stellenbosch University. The Diploma is aimed at people in full time management roles, although some of the module would be relevant to clinicians such as the family physician. There are 10 modules:

	Semester 1	Semester 2
Year 1	Leadership and Innovation	
	Health systems, policy & financing	Managing Self & Others

	Strategy, Marketing & Communications	Evidence & Information
Year 2	Leadership and Innovation	
	Finance & Governance	Quality, Clinical Governance & Patient Care Project Management
	Managing Operations	Health Technology & Infrastructure

Teaching also emphasises action learning and practical workplace-based experiential learning.

Prof Julia Blitz: Lessons from the UK

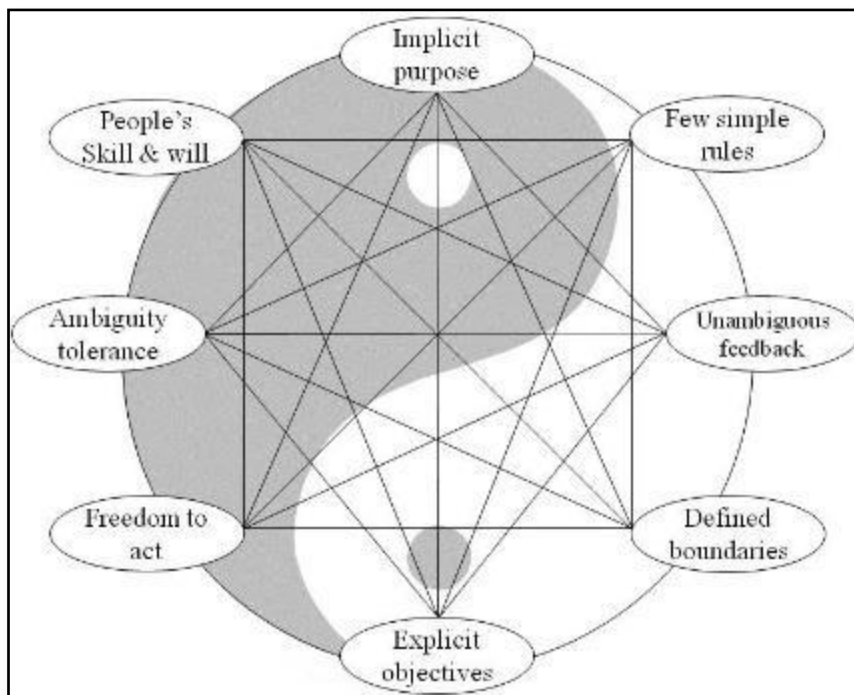
The project funded Prof Blitz to visit the UK and investigate how leadership and governance is tackled in the training of GPs. The concept of *collaborative leadership* is being promoted in the UK, which implies leaders who can motivate people, encourage participation, welcome questions, set challenges, encourage the sharing of ideas and learn positively from mistakes. The concept of leadership for complex systems, with uncertainty and ambiguity, was also mentioned. A model of healthcare leadership with 9 dimensions is used:



A coaching style of leadership fits well with this model. The book *Leadership Plain and Simple* (FED) by Steve Radcliffe is a key resource, as is the NHS leadership framework and the idea of lean management. Learning experiences include QI projects, mentoring and pairing with a manager. Assessment includes multi-source feedback, case-based discussion and audit.

Prof Bob Mash: Lessons from Belgium

Prof Mash visited Gent University to see how they approach the topic with their registrars in family medicine. The department is thinking about the concept of *complex adaptive leadership* [see the book *Complex adaptive leadership: Embracing paradox and uncertainty* by Nick Obolensky, Gower Applied Business Research, 2010]. This idea sees the need for leaders to leave behind the oligarchic assumption that organisations function as people and departments in hierarchy, defined by lines of authority and reporting, using the metaphor of machine. Instead leaders need to embrace the polyarchic realities that organisations function as complex systems with a balance between order and chaos. People and departments are in a network, defined by relationships and communication connectivity, with the metaphor of a living system. Leading complexity requires a paradoxical balancing of the following principles:



Dr Shadrick Mazaza: Oliver Tambo Fellowship Programme

Dr Mazaza spoke about the history of the programme and development of 4 modules on health policy, health economics, management and leadership. The programme was a collaboration between the UCT School of Public Health and the Graduate Business School aimed at middle and top management in the health sector. The curriculum emphasised the need to shift from a hierarchical to a systems view of the organisation as a manager and the need for experiential action-learning in the workplace and mentorship as a core component.

Prof Laurel Baldwin-Ragavan: Virtual Leadership Development Programme

Prof Baldwin-Ragavan at Wits with other colleagues has got involved with the VLDP. Again this programme emphasises the need to learn by solving local problems experientially and by doing self-development work. She made a number of observations about the topic of

leadership: (1) Leadership is always about how power is wielded or shared and is therefore a political issue – doctors feel uncomfortable to engage with political issues (2) People resist loss and not change because all change has winners and losers in terms of whose vested interests that triumph during change (3) Implementation of leadership is important in terms of whether it is top-down, bottom-up or as is now recommended exercised through networks. Networks though are also dynamic and related to power relationships. (4) We do not need to invent the curriculum as many countries have done this already e.g. NHS in UK (5) Issues of leadership and power always come with ethical and human rights issues (6) The use and interpretation of data is a key issue, can one provide evidence for the effectiveness of leadership training? (7) Finances – we need to think more about issues of cost-effectiveness in our systems (8) Leadership that can adapt to complexity is important

Review of current training on leadership and governance in family medicine programmes

The national unit standards for postgraduate training of family physicians have been agreed to and published. Unit standard 1 in its current form is shown below and deals with the issue of what was previously seen as management and administration.

Unit Standard 1 Effectively manage himself or herself, his or her team and his or her practice in any sector with visionary leadership and self-awareness in order to ensure the provision of high-quality, evidence-based care.	
Capability	Outcomes
A person who has achieved this standard is capable of effectively managing himself or herself, his or her team and his or her practice, regardless of the sector, shows self-awareness in his or her personal and professional approach and provides high-quality care based on current evidence.	<p>The following components of this capability should be demonstrated by the candidate.</p> <p>1.1 Manage himself or herself optimally by:</p> <p>1.1.1 Addressing his or her personal learning needs continually by assessing needs and participating in an appropriate programme of learning.</p> <p>1.1.2 Demonstrating growth and learning in response to identified needs</p> <p>1.1.3 Demonstrating responsible and efficient methods of self-management and self-care</p> <p>1.1.4 Demonstrating willingness to seek help when necessary</p> <p>1.1.5 Describing activities to enhance self-growth and development</p> <p>1.1.6 Demonstrating an ability to develop his or her own capacity to perform at the level that is expected of a family physician.</p> <p>1.2 Manage resources and processes effectively by:</p> <p>1.2.1 Describing and applying the applicable laws with respect to employment practices, labour relations, accounting and running a dispensing practice</p> <p>1.2.2 Interpreting basic financial statements</p> <p>1.2.3 Understanding and applying basic principles of budgeting, health economics, tax management and financial planning</p> <p>1.2.4 Planning viable health services in a systematic and rational way, incorporating the appropriate use of resources, including human and material resources.</p> <p>1.2.5 Planning, implementing and maintaining information- and record-keeping systems.</p> <p>1.3 Describe, evaluate and manage healthcare systems by:</p> <p>1.3.1. Demonstrating the ability to contribute to the management of a facility, sub-district and professional practice.</p> <p>1.3.2 Working effectively as a member of the district health care team, in any sector</p> <p>1.3.3. Demonstrating an understanding of the principles of the district health system, in the context of the national health system.</p> <p>1.3.4. Demonstrating the ability to plan and conduct a practice audit</p> <p>1.3.5. Implementing ongoing quality improvement activities.</p> <p>1.4 Facilitate clinical governance by:</p> <p>1.4.1 Critically reviewing research articles and applying the evidence in practice.</p> <p>1.4.2 Demonstrating the implementation of research and literature review findings in the management of problems in practice by, for instance, developing protocols for the practice.</p> <p>1.4.3 Adapting and implementing appropriate local, national and international clinical guidelines.</p> <p>1.4.4 Engaging in monitoring and evaluation to ensure high quality care.</p> <p>1.4.5 Implementing rational prescribing and diagnostic testing.</p> <p>1.4.6 Facilitating risk management processes.</p> <p>1.5 Work with people in the healthcare team to create an optimal working climate by:</p> <p>1.5.1 Communicating and collaborating effectively with members of the healthcare team and peers.</p> <p>1.5.2 Demonstrating the ability to manage and motivate personnel.</p> <p>1.5.3 Facilitating the development and implementation of a strategic plan.</p> <p>1.5.4 Demonstrating management and leadership skills within the context of a team.</p> <p>1.5.5 Effectively managing conflict with peers, staff and patients.</p>

Each programme gave feedback on how they currently train registrars on these learning outcomes.

Podcast recordings of some of these presentations are available from URL:

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University of Free State

They have a Practice Management Module as a series of lectures given in short contact sessions over 2-years and some self-study. The topics covered include: Family Medicine Foundations, Business Management (Private and Public), Financial Management, Human Resources, Leadership and Personal Development, Ethics, and Medico-legal issues.

Sefako Makgatho Health Sciences University

They have a Practice Management Module during the 2nd year of training that covers issues to do with finances, human resources, budgeting, and legislation. Registrars may have to offer leadership within the clinical team and address governance in their quality improvement project. The COPC and ethics assignments may also be relevant.

Stellenbosch University

They have replaced their module on Management & Administration (now an elective) with a new module on Leadership & Governance. During their contact time throughout the 4-years they receive ongoing group coaching in personal and leadership development as well as the Myers-Briggs Temperament Inventory, and sessions on health indicators and data and QI projects that made a difference. In 3rd year they complete a 12-week on-line module that focuses on

- Weeks 1-3: Your role as a leader.
- Weeks 4-8: Clinical governance and improving care within the context of the district health system.
- Weeks 9-10: Specific emphasis on the role(s) of the family physician within this system.
- Weeks 11-12: Think about long term developments with regards to leadership and clinical governance in your context.

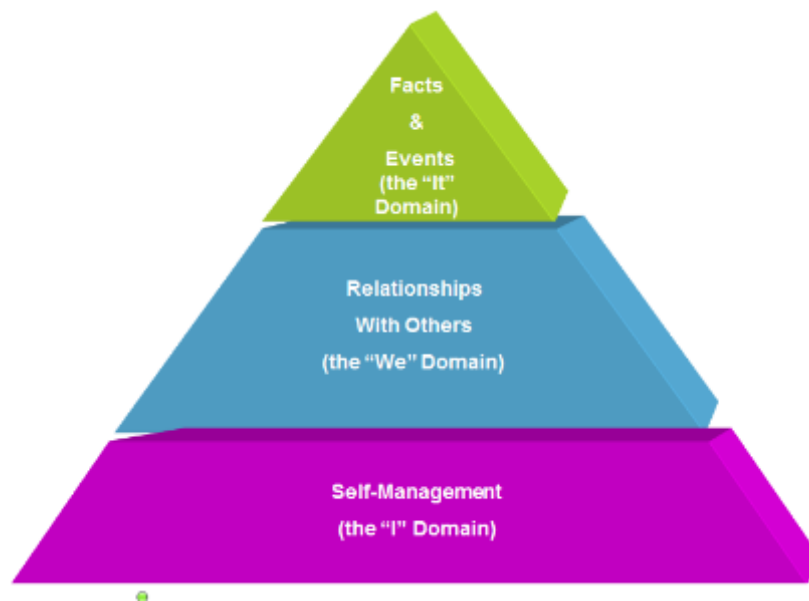
University of Limpopo

Need to give greater attention to leadership and governance in the curriculum. Leadership in the clinical setting is required and there is some content on practice management and the health system, but nothing systematically or comprehensively designed. This programme has recently gained independence due to the demerger of UL and SMU.

University of Cape Town

They have a module on Managerial Leadership that emphasises the following principles.

- Horizontal learning to be competent in the knowledge, skills and attitudes essential for your leadership toolkit – knowledge and technical expertise
- Vertical learning to transform ones mindset and emotional intelligence to be more wise and caring – complex adaptive leadership, cultivate relationships and navigate uncertainty.
- Developing leadership competence can be seen as three tiers – better self-management (the "I"), better relationships with others (the "we") and understanding the facts and events in your context (the "it").



Understanding the 4 Ps is important (personalities, private agendas, power plays, politics). Working with complementary opposites (see diagram above on complex adaptive leadership). Their approach is based on Personal (Self) Transformation, Values based leadership (The Allan Gray Centre for Values Based Leadership) and Innovative Leadership (The Bertha Centre for Social Innovation)

University of Kwazulu-Natal

There is currently no formal leadership and management training and no opportunity to reflect on leadership / management roles. The portfolio does support some skills in planning as do the projects on QI and COPC. Clinical leadership within the team is expected of registrars. They are exposed to many of the tools of clinical governance.

University of Pretoria

Current training is focused on private practice management: Managing self, Managing resources and processes (laws, setting up a practice, finances, information systems, human resources, dispensing), Teamwork and Clinical governance (Evidence based medicine, audit

and QIP). Need to train more for both public and private sectors, for both leadership as well as management and for change management skills.

University of Witwatersrand

They are in transition from part-time distance education programmes to full-time registrar programmes. They have mapped the learning outcomes into a cycle of didactic inputs across the 7 districts over a 3-year cycle that covers the content. The QIP and COPC assignments are also relevant and allow integration of skills. They have introduced chief registrars who are expected to take leadership within the programme. They have tested clinical leadership skills in a simulated disaster. The management of scarce resources is vital and more focus on the financial issues, for example NHI.

Walter Sisulu University

They have no module on leadership and governance per se, but cover some aspects of practice management through a series of seminars: the DHS, health economics, labour relations, quality assurance. They do a QIP.

Conclusion

The overall impression is that three programmes are not really addressing leadership and governance at all, while three are continuing with an outdated focus on private practice management, and three have attempted to revise their programmes in line with the new learning outcomes and current thinking on leadership and governance.

Consensus on leadership and the family physician

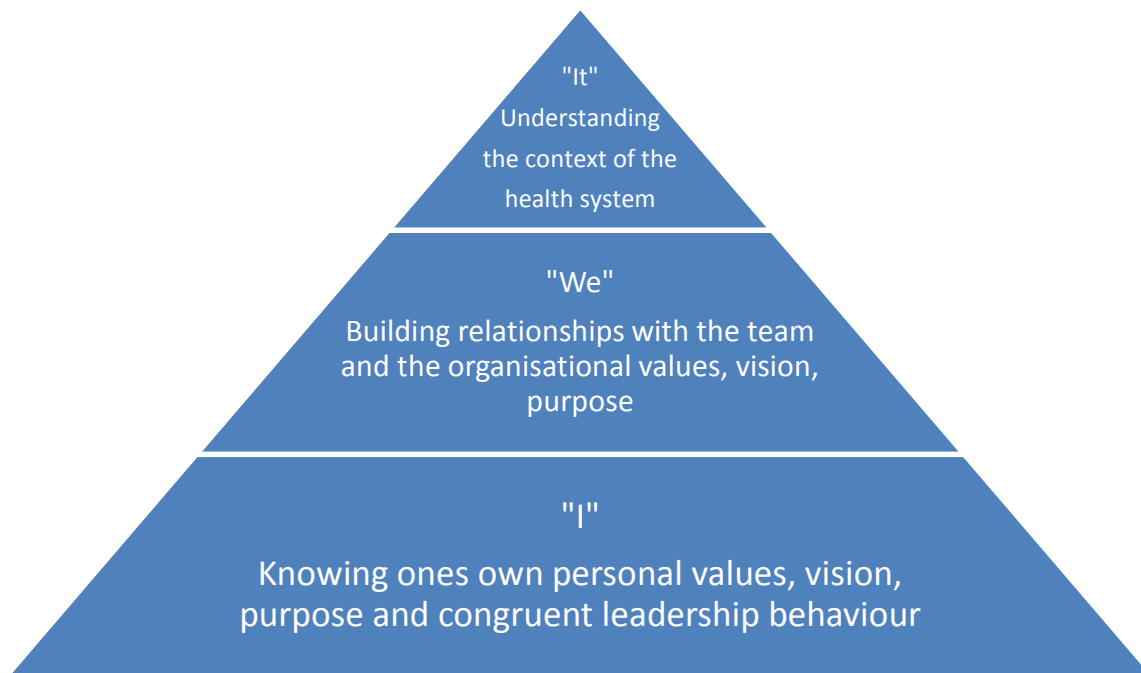
Important principles

Leadership was not seen as another specific role, but rather a set of competencies that become visible in all the roles of the family physician (care-provider, consultant, capability builder, supervisor, champion of clinical governance and COPC) and the definition that leadership is “authentic self-expression that adds value” summarised this well. The family physician should add value through their leadership ability in all their roles.

The healthcare system should be seen as a complex system and not just as a hierarchy or organogram. This implies that the concept of complex adaptive leadership [see above] should be embraced along with systems theory and complexity theory.

Conceptual model of leadership

The “I-we-it” model of leadership resonated most with the group as a conceptual model of developing leadership ability. It comes from a book by James Flaherty on ‘Coaching: Evoking Excellence in Others’.



The foundation of this is the “I” domain, which emphasises self-awareness, self-reflection, and self-management in terms of one’s own values, strengths and weaknesses as a leader, and how one needs to change and develop in one’s leadership styles and behaviour. A number of tools are available to assist with this (e.g. VIA Inventory of Strengths survey, Positive Leadership Assessment File, Myers-Briggs, Emotional intelligence) as well as reflective writing, group discussions and coaching.

The next important domain is the “we”, which focuses on building relationships and networks within which one can offer leadership. This domain emphasizes skills in communication, teamwork, mentoring or coaching others, advocacy and co-ordination. Leadership in this domain shows up strongly in terms of capability-builder, clinical training, clinical governance activities, and supporting COPC activities.

The next important domain is the “it”, which focuses on knowing the context of the health system within which one is being a leader. What are the important structures, processes and procedures? What are the important laws and policies?

Important issues for training

There was a consensus that training in leadership should include the following:

- A longitudinal and incremental/spiral approach that develops leadership capability over the course of the 4-years
- Experiential/action learning in the workplace around concrete problems
- Mentoring by other leaders or role models
- The trainers themselves are not that familiar with how to teach leadership and may need to also receive training and support
- Leadership capability can be applied in both the private and public sectors and there is no need to have separate training

Implications for learning outcomes

The learning outcomes 1.1, 1.5 and 1.3 should be revised to refer to leadership development and aligned with the “I”, “we” and “it” components of the model respectively. They are also re-numbered below as 1.1, 1.2 and 1.3

1.1 Develop him or herself optimally as a leader by:

- 1.1.1 Demonstrating self-awareness and reflection in terms of one’s personality, personal values, preferred learning and leadership styles, and learning and development needs.
- 1.1.2 Demonstrating effective methods of self-management and self-care
- 1.1.3 Demonstrating willingness to seek help when necessary
- 1.1.4 Demonstrating an ability for self-growth and personal development

1.2 Offer leadership within the healthcare team and district health system by:

- 1.2.1 Communicating and collaborating effectively
- 1.2.2 Demonstrating an ability to build capability, mentor or coach members of the healthcare team
- 1.2.3 Demonstrating an ability to engage and influence others through advocacy, group facilitation, presentations, critical thinking, or behaviour change counselling
- 1.2.4 Working effectively as a member of the sub/district healthcare team

1.3 Describe and contribute to the functioning of the district healthcare system by:

- 1.3.1 Demonstrating an understanding of the principles of the district health system in the context of existing and developing national legislation and policy
- 1.3.2 Demonstrating an ability to contribute to the management of a facility, sub-district, or district.

Consensus on clinical governance and the family physician

Important principles

While the FP may take responsibility for clinical governance they need to involve the whole healthcare team and network of resources in the processes and delegate responsibility for some tasks – in other words offer appropriate leadership. They need to lead and implement a pro-active process, but not necessarily do everything. Otherwise they risk burnout, being overwhelmed and failing to enable ownership of the process by the whole team.

Prioritisation, teamwork and managing one’s personal boundary are all important.

Clinical governance should pay attention not only to disease-specific or clinical processes (e.g. care for people with diabetes) but also systematic issues (e.g. continuity of care,

coordination of care between levels (referrals)) and the patient's perspective (e.g. experience, satisfaction, formal engagement through clinic committees)

Clinical governance requires an organisational culture that encourages openness, reflection, innovation, accountability and learning. The family physician should be aware of the organisational culture and their contribution to co-creating it through their own leadership.

Clinical governance is limited by the scarcity of resources and the extent to which the system supports a desire for improved quality of care.

The job description of the FP should clearly recognise their role in relation to clinical governance.

Important roles and competencies

The following roles and competencies were listed for the family physician:

- Ability to contribute to the development or revision of guidelines giving input from the DHS perspective
- Ability to facilitate the implementation of clinical guidelines within the sub/district
- Ability to improve quality of care by facilitating quality improvement cycles (including the audit of clinical care as one step in the cycle).
- Ability to improve cost-effectiveness(quality) through reflection on routinely collected data (monitoring and evaluation), particularly rational prescribing and use of investigations (accountability for resources)
- Building capability and quality care through teaching, training and mentoring
- Ability to manage risk and improve patient safety through reflection on significant adverse events (morbidity and mortality meetings) and use of root cause analysis
- Ability to critically appraise new evidence
- Ability to appraise the competence of new clinicians and set appropriate levels of independence vs. support
- Ability to evaluate the quality of care in relation to the relevant clinically-orientated national core standards

Important issues for training

Need to share approaches to the training of CG between departments. Other departments may have useful contributions e.g. pharmacy.

Does the learning portfolio capture all of the above activities and learning sufficiently?

Revision of learning outcomes

1.4 Lead clinical governance activities by:

1.4.1 Demonstrating the ability to lead a quality improvement cycle in practice

1.4.2 Demonstrating the ability to build capability through training, teaching and mentoring others in the healthcare team [see unit standard xx]

- 1.4.3 Facilitating reflection on health information (e.g. monitoring and evaluation, national core standards) in order to improve quality of clinical care (e.g. rational prescribing and use of investigations) in the sub/district
- 1.4.4 Facilitating risk management processes and improving patient safety (e.g. conduct morbidity and mortality meetings, assess competence of new clinical staff, perform root cause analysis) in the sub/district
- 1.4.5 Facilitating the implementation of clinical guidelines in the sub/district
- 1.4.6 Critically reviewing new evidence (e.g. research) and applying the evidence in practice
- 1.4.7 Contributing to the development or revision of guidelines by generating new evidence (e.g. perform research) or representing the viewpoint of the district health services in the process

Consensus on corporate governance and the family physician

Key principles

Corporate governance involves all the more traditional managerial tasks of finances and budgets, procurement and supply chain management, human resource management, and infrastructure. This is typically the role of the clinical manager and not the family physician.

Family physicians need to understand the principles of corporate governance so they can be “consciously incompetent” in this area and know how to engage, influence and ask the right questions. They do not need to be competent to perform all these tasks as this is the role of the clinical manager or equivalent.

Understanding the key principles and issues is generic and the principles can be applied equally in both the public and private sector. It is not necessary to run courses specifically targeted at both, remembering that the context of training is the public sector.

Important roles and competencies

The FP needs to ensure sufficient two-way engagement and communication with those responsible for corporate governance as these issues have a direct impact on clinical care. On the one hand they need to ensure that information on corporate governance policy, decisions and plans are shared with them and on the other that they have opportunities to give advice and advocate from the clinical perspective. This should not mean attending all of the managerial meetings and being able to set a clear boundary between their role as a family physician and the role of the clinical manager.

Being able to understand and influence corporate governance issues is key and this would require competency in motivating well, speaking to authority through the correct processes and structures, constructive engagement. Occasionally this might also mean knowing when to challenge outside the structures (whistleblowing etc.)

Key issues with training

The clinical and other managers in the DOH may be in a good position to inform registrars on how corporate governance works (although the capability of managers varies widely). Attachment to or mentoring from the managers might be useful.

Revision of learning outcomes

1.5 Understand and influence corporate governance:

- 1.5.1 Understand the principles of human resource management (e.g. labour relations, recruitment, disciplinary procedures, grievances)
- 1.5.2 Understand the principles of financial management (e.g. budgets, health economics, financial planning)
- 1.5.3 Understand the principles of procurement and infrastructure (e.g. supply chain, equipment, buildings)
- 1.5.4 Understand the principles of health information and record-keeping systems
- 1.5.5 Understand the principles of rational planning of health services
- 1.5.6 Be able to communicate effectively with those responsible for corporate governance

The way forward and final comments

By the end of the workshop there was remarkable consensus around the roles and competencies as well as the way in which the learning outcomes should be revised. The concept of leadership should be included in the wording of the other unit standards. Most of the discussion was in terms of how to teach these revised learning outcomes.

Key issues around teaching and training were:

- Need to more consciously train and teach on this issue, despite the existing learning outcomes many programmes have under-emphasised unit standard one.
- Need to include the topic of leadership and governance in the next edition of the Handbook
- Need to look at ways of sharing resources and material between programmes, feel free to contact each other
- Need to look at a variety of opportunities to upskill the trainers and tutors e.g. at annual conference, through in-service training at universities, through the various short courses on leadership and management,
- Many resources are available – the issue is what to choose that is applicable to our learning outcomes and context
- Follow up on implementation of this workshop through ETC of the SAAFPs

Key issues around assessment were:

- Start using 360-degree tools to assess impact of registrars
- Ensure L&G adequately reflected in the portfolio (e.g. assignments, case studies)

- Importance of appropriate weighting of assessment – reinforcing importance of L&G in training

Key issues around the role of the family physician were:

- Ongoing advocacy with the national and provincial departments of health is needed to align our view of leadership and governance with the DHS and how family physicians are appointed and their job descriptions
- Also to be clear about the boundaries and differences between clinical managers and public health specialists
- Remuneration of FPs in the private sector remains an issue



Dr Kerrin Begg presenting an overview of a Post-graduate Diploma in Healthcare Management

Appendix: The revised learning outcomes

1.1 Develop him or her-self optimally as a leader by:

- 1.1.1 Demonstrating self-awareness and reflection in terms of one's personality, personal values, preferred learning and leadership styles, and learning and development needs.
- 1.1.2 Demonstrating effective methods of self-management and self-care
- 1.1.3 Demonstrating willingness to seek help when necessary
- 1.1.4 Demonstrating an ability for self-growth and personal development

1.2 Offer leadership within the healthcare team and district health system by:

- 1.2.1 Communicating and collaborating effectively
- 1.2.2 Demonstrating an ability to build capability, mentor or coach members of the healthcare team
- 1.2.3 Demonstrating an ability to engage and influence others through advocacy, group facilitation, presentations, critical thinking, or behaviour change counselling
- 1.2.4 Working effectively as a member of the sub/district healthcare team

1.3 Describe and contribute to the functioning of the district healthcare system by:

- 1.3.1 Demonstrating an understanding of the principles of the district health system in the context of existing and developing national legislation and policy
- 1.3.2 Demonstrating an ability to contribute to the management of a facility, sub-district, or district.

1.4 Lead clinical governance activities by:

- 1.4.1 Demonstrating the ability to lead a quality improvement cycle in practice
- 1.4.2 Demonstrating the ability to build capability through training, teaching and mentoring others in the healthcare team [see unit standard xx]
- 1.4.3 Facilitating reflection on health information (e.g. monitoring and evaluation, national core standards) in order to improve quality of clinical care (e.g. rational prescribing and use of investigations) in the sub/district
- 1.4.4 Facilitating risk management processes and improving patient safety (e.g. conduct morbidity and mortality meetings, assess competence of new clinical staff, perform root cause analysis) in the sub/district
- 1.4.5 Facilitating the implementation of clinical guidelines in the sub/district
- 1.4.6 Critically reviewing new evidence (e.g. research) and applying the evidence in practice
- 1.4.7 Contributing to the development or revision of guidelines by generating new evidence (e.g. perform research) or representing the viewpoint of the district health services in the process

1.5 Understand and influence corporate governance:

- 1.5.1 Understand the principles of human resource management (e.g. labour relations, recruitment, disciplinary procedures, grievances)
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- 1.5.3 Understand the principles of procurement and infrastructure (e.g. supply chain, equipment, buildings)
- 1.5.4 Understand the principles of health information and record-keeping systems
- 1.5.5 Understand the principles of rational planning of health services
- 1.5.6 Be able to communicate effectively with those responsible for corporate governance